Final Invoice

Division of Medical Services
P.O. Box 326
Jefferson City, MO 65102-0326
Invoice Number: **001234**
Date: **MM/DD/YY**

Case Number: **<DCN>**
<Case Name>
<Street Address>
<City, State Zip>

Your premium for **Medical Assistance for Workers with Disabilities** health care coverage for the month of <NEXT MONTH> is due. Your premium amount is **<$000.00>** per month and due by <CURRENT MONTH 25TH>. Payment must be received for you to have coverage for the month of <NEXT MONTH>. Failure to make payment will result in your eligibility for **Medical Assistance for Workers with Disabilities** health care coverage ending. **Your eligibility for this program will end because you have not paid your premium for four consecutive months.**

You must pay by mailing a check or money order made payable to **Division of Medical Services** for the full amount of **<$000.00>**. Write your case number on the check or money order. Coverage cannot begin before your premium is received. Payment must be received by <current month 25th> for your coverage to continue uninterrupted. Please send the attached invoice with your payment.

If you want to have your premium automatically withdrawn from your bank account each month, please fill out the enclosed authorization form and mail it to the address on the invoice. It will take 30 days to process this request.

You have the right to appeal this decision. You can request a hearing within 90 days from the date of this letter by calling 1-800-392-2161 or (573) 751-6527. You can also write the:

Division of Medical Services
Recipient Services Unit
P.O. Box 6500
Jefferson City, MO 65102

If your income or address changes, call your county Division of Family Services office to report this change. You must report any changes within 10 days.

If you have questions regarding payment, call the **Premium Collection Unit** toll-free at 1-877-888-2811.

Please tear on dotted line Form RECINV 11/08/02

Please Send with your payment

DCN: **<DCN>**
<Case Name>
<Street Address>
<City, State Zip>

Invoice Number: **001234**
Date: **MM/DD/YY**
Amount: **<$000.00>**
XXXXXXXX 00001234 0000 01 000000

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